



## Center for Medicaid and CHIP Services

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### Medicaid and CHIP FAQs: Coordination between Medicaid/CHIP and the Federally-Facilitated Marketplace

**Q1: How is CMS envisioning the “shared eligibility service” that will support interactions between insurance affordability programs and help ensure a seamless enrollment experience for consumers?**

**A1:** The process for making a MAGI-based eligibility determination is largely the same for all insurance affordability programs. The Affordable Care Act requires a single, streamlined application, accompanied by a similar set of business rules and verification processes, and an adjudication work flow that is largely identical between Exchanges, Medicaid and CHIP programs.

It is expected that State agencies that receive Federal funds from CMS to establish State-based Marketplaces and provide for Medicaid and CHIP expansions coordinate efforts to produce a shared eligibility service or system that relies on a shared IT infrastructure and as such, cost allocate this service.

A shared eligibility service is not the same as one system. We define an eligibility service as a set of IT functions that produce an eligibility determination based upon MAGI. (For more information, see IT Guidance 2.0, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/exchangemedicaiditguidance.pdf>.) The service incorporates an application, a set of verifications (for citizenship, income, residency, etc.) and business rules that together determine how much financial assistance a consumer should receive to acquire affordable health insurance.

While policies codified in final regulations allow legal authority for eligibility determinations to remain with state Medicaid agencies (for Medicaid) and Exchanges (for premium tax credits and cost-sharing reductions), the underlying business rules and processes are nearly identical, and should, to the maximum extent practical, rely upon a shared IT service(s) and infrastructure.

**Q2: Will the agreements between Medicaid/CHIP agencies and Exchanges regarding coordination be subject to public disclosure and/or public comments?**

**A2:** The agreement between Medicaid/CHIP agencies and Exchanges regarding coordination must be available to the Secretary upon request and will be subject to applicable disclosure laws, such as the Freedom of Information Act.

**Q3: Will the Federally-Facilitated Marketplace (FFM) only do assessments of Medicaid and CHIP eligibility or if a State desires will the FFM also make eligibility determinations for Medicaid and CHIP?**

**A3:** States can work with the Federally-Facilitated Marketplace (FFM) regarding Medicaid and CHIP eligibility determinations in one of two ways. The State may either establish an agreement whereby the FFM assesses applicants for Medicaid/CHIP eligibility based on MAGI and then transfers the applicants' electronic accounts to the State Medicaid or CHIP agency to complete the eligibility determination. Or the State may elect to accept MAGI-based eligibility determinations completed by the FFM as final determinations. Regardless of the approach, the process should be as seamless as possible for the applicant with most eligibility determinations completed in near real-time as specified in our eligibility final rule at 435.912.

**Q4: In the case where the Marketplace is conducting an eligibility assessment and then transferring the applicant's information to the State Medicaid or CHIP agency to complete the eligibility determination, what standards will the FFM use to make the assessment for Medicaid and CHIP eligibility?**

**A4:** The FFM will utilize the State's Medicaid and CHIP eligibility rules for conducting both eligibility determinations and eligibility assessments. This will include application of the State's MAGI income standards and related eligibility rules for the MAGI population. The FFM will also rely on a robust verification protocol that is consistent with Medicaid and CHIP regulations but which might not be the same protocol the State is otherwise using.

If a State accepts assessments of eligibility from the FFM and chooses to make the final eligibility determinations itself, once an individual has been assessed as Medicaid/CHIP eligible, their electronic account would be transferred to the State Medicaid or CHIP agency, which will complete the eligibility determination. This process will include any additional verification required by the State that is consistent with the Federal verification regulations.

**Q5: Can the Marketplace determine Medicaid eligibility for non-MAGI groups?**

**A5:** If the Marketplace is a governmental entity, States will have the option to enable their State-based Marketplace (SBM) to make Medicaid eligibility determinations for non-MAGI eligibility groups. Depending on the arrangements made in each State, such an SBM can make *all* Medicaid eligibility determinations, only eligibility determinations based on MAGI, or assessments of eligibility based on MAGI. The FFM will not be making Medicaid eligibility determinations for non-MAGI groups; the FFM will either do final determinations or assessments for the MAGI eligibility groups.

**Q6: Is CMS planning to draft a standard agreement for State Medicaid and CHIP agencies to use with the State-based Marketplace?**

**A6:** Yes. CMS is working with States to develop a model agreement, and it is one of the tools that the Coverage Expansion Learning Collaborative will be considering.

**Q7: In situations where an FFM makes Medicaid eligibility assessments rather than full determinations, will the determination be able to happen in real-time?**

**A7:** The goal is to have a seamless experience for consumers, with eligibility determinations made as quickly as possible regardless of which approach to eligibility determinations is in effect in a particular State. CMS will be establishing, in collaboration with States and with an opportunity for public input, data reporting measures that will allow States, CMS and the public to have information about the enrollment process including the timing of eligibility determinations under different design approaches.

**Q8: Can a State require Medicaid applicants who are applying to a State Medicaid agency to apply using the single streamlined application and therefore not get screened for a non-MAGI eligibility category?**

**A8:** The single streamlined application will contain questions that are designed to identify individuals who may be eligible for Medicaid on a basis other than MAGI. Today, many States use a simplified application that includes questions about disability status or the need for long-term care. The single streamlined application will have similar questions to help identify individuals who may need a Medicaid determination on a basis other than MAGI. Once identified, the individuals would be asked to complete a supplemental application, or a separate application for non-MAGI groups. The application will be developed with State and public input; we will be interested in suggestions on how best to screen for non-MAGI eligibility.

**Q9: Is there a potential conflict with the Medicaid requirement to process an application within 45 days and the Exchange rule that allows applicants 90 days to respond to requests to resolve information that is not reasonably compatible?**

**A9:** The requirements are different, but they are not in conflict. The 45-day limit for Medicaid is the outer boundary limit by which a State must determine Medicaid eligibility for all individuals who apply on a basis other than disability, and as discussed above, we expect much quicker determinations in most cases. The Medicaid program provides a reasonable opportunity period for individuals whose citizenship or immigration status cannot be verified. Medicaid provides benefits for individuals during their reasonable opportunity period, who are otherwise eligible for Medicaid. The Exchange rule provides for a 90-day reasonable opportunity period for all factors of eligibility. The Exchange determines eligibility without delay and then provides a 90-day reasonable opportunity period for the applicant to provide any additional required information.

**Q10: What does it mean for an individual to withdraw their Medicaid application in order to receive a determination of eligibility for Advance Premium Tax Credits (APTCs)?**

**A10:** In a State where the Marketplace makes Medicaid and CHIP eligibility assessments, but not eligibility determinations, there are certain requirements that the Marketplace must follow (found at 42 CFR 155.302(b)) in order to ensure a smooth transition between programs. When an eligibility assessment reveals that an applicant is potentially eligible for Medicaid or CHIP, the Exchange must transmit the individual's electronic account to the Medicaid or CHIP agency for completion of the eligibility determination.

However, when an eligibility assessment reveals that an applicant does not appear to be Medicaid or CHIP-eligible, the Exchange does not have the authority to deny Medicaid/CHIP eligibility (because that is not the arrangement in that State). The Exchange has the responsibility to notify applicants that they do not appear to be Medicaid/CHIP-eligible and provide them with the opportunity to either seek a formal Medicaid eligibility determination (which would delay the eligibility determination for an APTC), or to withdraw their application for Medicaid/CHIP and receive a determination for an APTC and a cost-sharing reduction (section 155.305(b)(4)). We will address in further guidance how the withdrawal will be addressed in the case of an appeal of an APTC decision.

**Q11. Will the Federally-Facilitated Marketplace apply Medicaid policies and verification procedures differently under the “assessment” and “determination” models?**

**A11:** In an assessment model, the Federally-Facilitated Marketplace will not make a final Medicaid determination. Instead, the Federally-Facilitated Marketplace will transmit the account to the Medicaid or CHIP agency when they have evaluated the individual and identified him or her as Medicaid or CHIP eligible, and the Medicaid or CHIP agency will make the formal determination. In a determination model, the Medicaid or CHIP agency delegate the authority to make determinations to the Federally-Facilitated Marketplace. In both an assessment and determination model, as described in more detail in 42 CFR §435.1200, the FFM will utilize the same set of eligibility criteria, including selected state-specific options and standard verification procedures. If the state agency chooses the determination model, it must accept the FFM determination as final.

If the state chooses the assessment model, it must accept findings made by the Federally-Facilitated Marketplace relating to a criterion of eligibility, as long as the FFM applies the same policies and verification procedures as those the state agency employs. In a state with a separate CHIP agency, the state Medicaid and CHIP agencies can make different choices allowing the FFM to make an assessment or determination. States must choose either the assessment or determination model for all applications; they may not choose between models on a case-by-case basis. States will need to indicate their assessment or determination decision to CMS in a State Plan Amendment, as well as in the Memorandum of Agreement it signs with the FFM.

**Q12. In an assessment model, an applicant may be assessed eligible by the Federally-Facilitated Marketplace and later receive a determination as ineligible by the state Medicaid/CHIP agency. Does the state Medicaid agency need to communicate the eligibility finding to the FFM?**

**A12:** Yes. In an assessment model, where an applicant is assessed eligible by the Federally-Facilitated Marketplace and later found to be ineligible by the state Medicaid agency, the state must transfer the account to the FFM. Once received, the state Medicaid determination will be accepted and the account will be assessed by the FFM for enrollment in a qualified health plan (QHP) and eligibility for Advanced Premium Tax Credits/Cost Sharing Reductions.

For the determination model, as discussed in §435.1200(c), as governed by the agreement signed between the Medicaid agency and the FFM, the FFM determines eligibility for individuals applying for Medicaid/CHIP based on MAGI, and the state Medicaid or CHIP agency agrees to accept eligibility findings made by the FFM.

**Q13. In an assessment model, if an applicant applied via the Federally-Facilitated Marketplace and is found eligible for Medicaid or CHIP, how will the FFM coordinate with the state Medicaid or CHIP agency regarding eligibility, enrollment, redeterminations, or renewals for Medicaid/CHIP?**

**A13:** For individuals assessed eligible for Medicaid/CHIP by the Federally-Facilitated Marketplace, their account will be transferred to the state Medicaid/CHIP agency for a final determination. Once enrolled in Medicaid/CHIP, regardless of where the initial application was submitted, all updates, redeterminations and renewals are handled by the enrolling entity (e.g., the state Medicaid/CHIP agency). No further coordination would be needed with the FFM except when an individual is found ineligible for Medicaid or CHIP during the redetermination process. In this case, the state agency would transfer the individual's account to the FFM to be assessed for enrollment in a qualified health plan (QHP) and eligibility for Advanced Premium Tax Credits/Cost Sharing Reductions. The Federally-Facilitated Marketplace will not handle redeterminations or renewals for Medicaid/CHIP and will refer individuals to the appropriate site in the state as appropriate.

**Q14. Will the Federally-Facilitated Marketplace integrate its enrollment file with the state's client registry so that data for households participating in both state programs and the Marketplace can be synchronized? Will the FFM routinely check the Medicaid/CHIP enrollment files to determine any overlap between the FFM and Medicaid/CHIP enrollment logs?**

**A14:** No. There will not be integration of the FFM and states' client registries. Instead, the Federally-Facilitated Marketplace will both verify current Medicaid/CHIP enrollment as part of the application, and will also conduct quarterly checks of the Medicaid/CHIP enrollment files to determine any overlap with FFM enrollment logs.

*Originally released May 2012 and April 2013*